

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007445

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 15

FILED FEB 18 1963

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59				
2542				
2541				
3				
4 0				
5 1				
6				
7 0				
8 2				
94200	SHOULD READ	BY AFFIDAVIT OF	MEDICAL CERTIFICATION	ITEM NO.
10				
11				
12 2-0				
13 3-0				

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission)	
a. COUNTY <u>Lafayette</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		c. CITY OR TOWN <u>Higginsville</u>	
Length of stay in 1b <u>20 days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>705 Main</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Weston Powell</u>			4. DATE OF DEATH Month Day Year <u>January 24 1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-31-1885</u>
9. AGE (last birthday) <u>77</u>		IF UNDER 1 YEAR Months <u>25</u> Days <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Orchardman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>	11. BIRTHPLACE (City and state or country) <u>Near Higginsville, Mo. USA</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Edward Burr Powell</u>	
13b. MOTHER'S MAIDEN NAME <u>Elizabeth Emison</u>		14. NAME OF HUSBAND OR WIFE <u>Kathryn Doss Powell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>1-2-20-60-0</u>	
17. INFORMANT <u>Mrs. Kathryn Powell</u>		Address <u>Higginsville, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>			Years - <u>0</u>
DUE TO (b) <u>Arterio Sclerosis of Large Arteries</u>			
DUE TO (c) <u>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bilateral Pneumonitis, Pulmonary fibrosis</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown:
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>Aug. 28, 1951</u> to <u>January 24, 63</u> last saw him alive on <u>January 23-63</u>			
Death occurred at <u>9:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. Signature <u>T. Koppeswink, M.D.</u> (Degree or title)		22b. ADDRESS <u>Higginsville, Missouri</u>	22c. DATE SIGNED <u>2-7-63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-27-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City</u>	23d. LOCATION (City, town, or county) <u>Higginsville Missouri</u>
24. FUNERAL DIRECTOR <u>Forrest A. Hoefler</u> ADDRESS <u>Higginsville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-9-63</u>	26. REGISTRAR'S SIGNATURE <u>Manuel Eastman</u>

6867 6 T 833
FEB 19 1963

Left with Doctor

2-4-63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Frank K. Hooper

Licensed Embalmer No. 4801

P. O. Address Higginsville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.